MDR Tracking Number: M5-04-1941-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 03-01-04.

The IRO reviewed established evaluation/management office, therapeutic exercises, therapeutic activities, gait training, re-education training for D, analysis of Data, self care/home, therapeutic procedure prolonged service rendered from 07-24-03 through 10-22-03 denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-10-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99455 date of service 11-01-03 denied with denial code F. The requestor did not submit relevant information to support delivery of service. No reimbursement recommended.

CPT code 99358 date of service 11-01-03 denied with denial code G. Per Rule 133.304(c) reimbursement is recommended in the amount of $45.00.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for date of service 11-01-03 in this dispute.

This Findings and Decision and Order are hereby issued this 5th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

July 3, 2004

Re: IRO Case # M5-04-1941
IRO Certificate #: 4599

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is a Board certified in Physical Medicine and Rehabilitation, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service
2. Explanation of benefits
3. Initial chart note 2/17/03
4. Medical records review 6/27/03
5. RME 12/23/03
6. Chart note 1/5/04, 9/22/03
7. D.C. notes 7/9/03, 7/11/03
8. Progress notes of treatment center 7/15/03 – 9/9/03
9. M.D. records
10. D.O. records
11. Report cervical, thoracic, lumbar spine, and left shoulder x-rays 3/1/03
12. Report lower extremities NCS and evoke potentials 7/2/03
13. Reports MRI lumbar spine and MRI left shoulder 4/17/03
14. Psychological evaluation 9/25/03
15. FCE 10/3/03
16. Report medical evaluation 10/10/03

History

The patient was working on a dock when he slipped and fell backwards, landing on his buttocks and left outstretched hand on ___. He was taken to the ER where an x-ray showed a fractured coccyx. Pain medications were prescribed and the patient was discharged. He followed up with his D.C. on 2/27/03. X-rays were obtained that were normal, and did not show evidence of a coccyx fracture. Physical therapy and chiropractic treatment were started. MRIs of the lumbar spine and left shoulder were obtained on 4/17/03 that showed a disk protrusion at L4-5 and a normal shoulder. Electrodiagnostic testing on 7/2/03 was positive for lumbosacral radiculopathy. The patient had further medical evaluation and eventually underwent three lumbar epidural steroid injections. Lumbar facet injections were also recommended. Orthopedic consultation led to a left subacromial bursa injection. The patient underwent psychological evaluation on 9/25/03 and a work hardening program was recommended. A 10/3/03 FCE rated the patient at a medium physical demand level. His job requires a heavy to very heavy physical demand level.

Requested Service(s)

Estab E/M off, therapeutic exercises, therapeutic activities, gait training, re-education, training for D, Analysis of Da, self care/home, therapeutic procedure, prolonged service 7/24/03 – 10/22/03

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient was started on physical therapy after the injury, and it continued until at least

November 2003. The patient's shoulder improved, but he continued to complain of pain in

his low back and numbness in his legs. The patient had abnormalities on MRI and electrodiagnostic testing. The physical therapy notes for the dates in this dispute report continued pain without any sustained benefit or progress. Physical therapy five months past injury would not be considered reasonable or medically necessary. Further more, the records provided for this review do not document any medical necessity for the continued physical therapy treatments, for what appears from the records to be an excessive amount of time. Based on the records provided, the patient should have been transitioned into a home exercise program and returned to work with restrictions by the time of the period in dispute.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.